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ABSTRACT

This paper provides the results of a review of the empirical literature on interventions with antisocial problem behavior Hispanic youth. It explores the process of developing and evaluating culturally competent interventions. A review of a number of interventions, focusing on three in particular, suggests that cultural conflict is at the root of symptomatic behavior among Hispanic children and adolescents. A major program of research has been conducted by researchers from the Spanish Family Guidance Center/Center for Family Studies at the University of Miami (Florida). This center has been working toward appropriate interventions with Hispanic children and adolescents since 1972. As part of this effort, researchers at this center have studied the strains of acculturation. Results of studies at the University of Miami have suggested that structural family therapy is well suited for treating intergenerational and intercultural problems. The Center has developed Bicultural Effectiveness Training to enhance bicultural competence and family functioning, and this training has been an element in the development of Strategic Structural Systems Engagement to restructure patterns of family functioning. Evaluations have supported this approach and are serving as a basis for more refined interventions with a cultural competence focus. (Contains 55 references.) (SLD)

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CULTURALLY COMPETENT PSYCHOSOCIAL INTERVENTIONS WITH ANTISOCIAL PROBLEM BEHAVIOR IN HISPANIC YOUTH

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CULTURALLY COMPETENT PSYCHOSOCIAL INTERVENTIONS WITH ANTISOCIAL PROBLEM BEHAVIOR IN HISPANIC YOUTH

A major concern in the literature on antisocial problem behaviors has been the development and evaluation of interventions to prevent or reduce the occurrence of these problem behaviors in children and adolescents (Kazdin, 1987; Tolan, Guerra, & Kendall, 1995; see also Guerra, Attar, & Weissberg, this volume). An important corollary of this concern is the increased need to identify or develop culturally competent interventions to serve ethnic minority populations (Kazdin, 1993; Sue, Zane, & Young, 1994; Tolan et al., 1995). The success of interventions with antisocial problem behavior youth may depend greatly on the social and physical context in which interventions are delivered (e.g. Bourdin, Mann, Cone, Henggeler, Fucci, Blaske, & Williams, 1995). Ensuring that the context of the intervention and the method of service delivery is compatible with the expectations of the participants/clients increases the probability of a successful intervention. There is also recognition of how the major contexts for intervention,-- the family, school, or community,-- are each embedded within the context of culture (Szapocznik & Kurtines, 1993). Clearly, recognizing the influence of culture and considering its potential influence at all levels of an intervention, from theoretical background, to intervention design, to staffing and implementation, to evaluation, is critical to the overall success of the intervention.

While progress has been made in studying the mental health needs of culturally diverse groups, research on the development and evaluation of culturally competent psychosocial interventions with culturally diverse populations is sparse (Sue, et al., 1994). The construction of culturally competent interventions involves more than sensitivity to issues of culture. It reflects

the acquisition and mastery of knowledge and skills required to fully integrate a cultural perspective into an intervention in such a way that participants will accept it, the probability of success increases and the ensuing gains will be valued by the participants (Orlandi, 1992; Institute of Medicine, 1994). Culturally competent interventions are the result of the cumulative progress of knowledge in which advances in the theoretical domain contribute to innovative research, which in turn, informs theory and guides the development of culturally competent interventions. Systematic programs of research create a unique context for the evolution of culturally competent interventions. The systematic nature of these research programs is such that advances are not always ground breaking, and lessons are frequently hard-won, but the cumulative knowledge gained and the diversity of the lessons creates the setting from which culturally competent interventions emerge.

This chapter has two primary aims. The first aim is to provide the results of a review of the empirical literature on interventions with antisocial problem behavior Hispanic youth. The second, more general aim, is to discuss the process of developing and evaluating culturally competent interventions and several basic issues which must be addressed along the way.

A Review of the Literature on Culturally Competent Interventions with Hispanics

A systematic search of the literature from 1974-1995 using the computerized PsychLit data base was conducted to identify programs of intervention research with Hispanic antisocial and behavior problem youth that have yielded empirically tested, culturally competent interventions. The results of the search identified only two systematic programs of intervention research; one at the Hispanic Research Center at Fordham University (Rogler, Malgady, & Rodriguez, 1989; Malgady & Rodriguez, 1994), and the other, our own at the University of

Miami's Spanish Family Guidance Center and the Center for Family Studies (Szapocznik et al., 1996). No randomized studies of intervention research with Hispanic antisocial youth were found outside of these programs. However, the literature search did identify a broad spectrum of work including an array of clinical reports, often presenting descriptive observations of values, beliefs, and customs associated with Hispanic culture, small cross-cultural research studies comparing two or more ethnic/cultural groups, and clinicians' descriptions of Hispanic values and reflections on the implications for treatment. Despite this large literature, most of these observations have not been tested with controlled observations.

Empirical Studies of Interventions with Hispanic Youth

The Hispanic Research Center at Fordham University

Lloyd Rogler and his colleagues at the Hispanic Research Center have produced a systematic program of research investigating the nature and relationship between cultural factors and mental health in Hispanics (see Rogler, et al., 1989; Malgady & Rodriguez, 1994). While not specific to children and adolescents manifesting antisocial behavior problems, this program demonstrates the development and evaluation of culturally competent interventions and has implications for prevention and treatment of antisocial problem behaviors. The program of research has followed a conceptual framework which organized their work into five phases of research progressing from 1) the identification of factors associated with mental health problems in Hispanics to 2) help seeking efforts, to 3) evaluation and diagnosis of client disorders and problems, to 4) implementing therapeutic interventions, to 5) the client's resumption of post-intervention social roles (Rogler et al. 1989). Building on prior phases, this research program has yielded several empirical studies investigating the efficacy of culturally competent treatment

modalities for Puerto Rican children, adolescents, and adults (c.f. Costantino, Malgady, & Rogler, 1986; Malgady, Rogler, & Costantino, 1990a; 1990b).

In their initial intervention study, Costantino, et al. (1986), integrated Puerto Rican *cuentos* (folktales) to convey a cultural theme or moral within a framework of modeling therapy. One intervention used the cuentos in their natural form; a second adapted these cuentos to bridge Puerto Rican and American culture. The design also included an art/play therapy condition and a no-intervention control. Two hundred ten Puerto Rican children (grades kindergarten through 3; mean age = 7.45 years) were stratified by sex and grade and randomly assigned to one of the four intervention conditions.

Analyses revealed immediate treatment effects on anxiety symptoms, but only for first graders. First graders who participated in the adapted cuento modality demonstrated significantly lower levels of anxiety symptoms when compared to both control conditions. Children in the original cuento therapy showed lower anxiety compared to the no-treatment control group, but were not significantly different from the art/play control group. However, one year follow-up treatment effects were evident for all grades, with both the original and adapted cuento groups showing reduced anxiety in comparison to the two control groups. Treatment effects for social judgment for both experimental treatments were evident only immediately following treatment and not at follow-up. In comparison to the art/play control group, both cuento interventions demonstrated reductions in conduct problems (aggression, disruptiveness, and inability to delay gratification). Yet, neither experimental intervention showed effects when compared to the no-treatment control group.

In their second intervention, modifications were made to develop a cuento therapy for

high risk Puerto Rican adolescents. Biographical stories of prominent Puerto Ricans were used to expose the youth to achieving role models in an effort to promote ethnic pride, ethnic identity, and adaptive behaviors for coping with the stresses of poverty, discrimination and urban life (Malgady et al 1990b). By integrating themes of cultural conflict within the stories, Malgady and colleagues were able to highlight the real life struggles of these adolescents attempting to bridge two cultures. Forty male and fifty female Puerto Rican adolescents in grades 8 and 9, identified to be at elevated risk by teacher ratings of behavior problems, were randomly assigned to either the experimental intervention or an attention control. Results indicated that the experimental intervention was more effective in reducing anxiety symptoms and in increasing self concept and ethnic identity than the attention control. These results were moderated by sex and father's presence in the family structure. In households in which the father was absent, treatment enhanced self-concept and ethnic identity. However, in households in which the father was present, treatment did not affect males' self concept and ethnic identity, but had a negative effect on adolescent girls' self-image.

This unexpected negative finding highlights the need for understanding the complex interactions between important aspects of the adolescents' social contexts, such as family composition or intrafamilial relationships, gender, and the broader context of culture. Even sophisticated culturally sensitive intervention models may have unintended effects. Given the complexity of the relations and processes interventions try to modify, it should not be surprising that they are not universally effective. But the ensuing research task becomes using these results to inform theory and future research endeavors which will yield improved interventions targeting newly recognized relations.

A third study from the same team investigated the storytelling modality based on pictorial stimuli, rather than verbal and/or written stimuli (Costantino & Rivera, 1994). Eight pictures from the Tell-Me-A-Story (TEMAS) thematic apperception test (Costantino, 1987) depicting a variety of multiracial Hispanic characters in culturally appropriate family school and urban settings were used as the cultural content of the intervention. The treatment, conducted in a group format, involved three phases; producing a composite story about the picture, sharing personal experiences and feelings, and finally, role playing and reinforcement of imitative behaviors. High risk Hispanic children in grades 4-6 were recruited to participate and were screened using a diagnostic interview. Students were selected for the study if they were among the 30 most symptomatic in the diagnostic categories of conduct, anxiety, and phobic disorders. Students were stratified by grade and sex and randomized to experimental or attention control conditions. Results indicated that the experimental intervention produced immediate post-intervention effects on anxiety and phobic symptoms and on behavioral conduct in school as rated by their teachers.

The theoretical notion underlying all three of these interventions is that cultural conflict is at the root of symptomatic behavior among Hispanic (Puerto Rican) children and adolescents (Malgady, et al., 1990a; Malgady & Rodriguez, 1994). Given this idea as the primary theoretical structure, the research group has focused on developing culturally competent interventions with the resolution of cultural conflict as their primary goal. In designing culturally competent interventions, Rogler and his colleagues have used the client's cultural values as a "vehicle" for the therapeutic intervention (Costantino & Rivera, 1994). Results of these three outcome studies yielded findings suggestive of the efficacy of these intervention modalities in

reducing psychological symptoms, or increasing self-image in Hispanic youth.

The Spanish Family Guidance Center/Center for Family Studies

The second major program of research culminating in the empirical evaluation of culturally competent interventions has been conducted by our own team of researchers from the Spanish Family Guidance Center/Center for Family Studies at the University of Miami. In describing our work, we will illustrate the evolution of a systematic program of research for developing and evaluating prevention and treatment interventions with antisocial problem behavior Hispanic youth. To advance the investigation and the prevention and treatment of Hispanic adolescent antisocial problem behavior, we reframed the challenges inherent to culturally competent intervention research into research questions, the answers to which could be pursued within the framework of a rigorous program of systematic research. In translating these challenges into research questions, methodological issues had to be resolved, resulting in some of our most important breakthroughs in theoretical understanding. Likewise, advances in our theoretical understanding have resulted in progress in overcoming obstacles to resolving clinical problems as well as in some of our most important methodological advances (Szapocznik & Kurtines, 1989, 1993; Szapocznik, Perez-Vidal, Hervis, Brickman & Kurtines, 1990; Szapocznik, Kurtines, Perez-Vidal, Hervis, & Foote, 1990). Thus, the evolution of our approach has been guided by the view that research must be both a final step in the completion of each stage of knowledge development and a solid foundation from which to pursue new theoretical and applied breakthroughs.

With respect to theory, our approach draws on both the structural (Minuchin, 1974; Minuchin and Fishman, 1981; Minuchin, Rosman & Baker, 1978) and strategic (Haley, 1976;

Madanes, 1981) traditions in family systems theory. With respect to application, our work has focused on developing prevention and treatment interventions for antisocial problem behavior and drug abuse among Hispanic children and adolescents. This research has involved the investigation of the cultural characteristics of our Hispanic population (primarily Cuban American in the 1970's and 80's, but increasingly Nicaraguan, Columbian, Puerto Rican, Peruvian and Salvadoran in the 1990's), the role that cultural factors may play in the process of prevention and treatment, and the role cultural factors may play in determining differential outcomes. Our efforts to develop and investigate novel, theoretically based, and culturally appropriate interventions which can be used in the prevention and treatment of behavior problems and drug abuse among Hispanic youth has led directly to a structural, and family-based approach to working with Hispanic families (Szapocznik, Kurtines & Santisteban, 1994; Szapocznik et.al., 1996).

In 1972 the Spanish Family Guidance Center was established in Miami, Florida in response to an alarming increase in the number Hispanic adolescents with antisocial problem behaviors. One of the first challenges we encountered was to identify and develop a culturally appropriate and acceptable treatment intervention for antisocial problem behavior Cuban youth. Our starting point was to develop a better understanding of how the transplanted Cuban culture resembled, and differed from, the mainstream culture of the Miami area. To accomplish this, a comprehensive empirical study on value orientations was designed based on the pioneer work on worldviews by Kluckhohn and Strodtbeck (1961). The major study on value orientation (Szapocznik, Scopetta, Aranalde & Kurtines, 1978) that ensued determined that a family-oriented approach in which therapists take an active, directive, present-oriented leadership role matched

the expectations of our population. This was the first indicator that a structural and systemic approach to family therapy was particularly well suited for this population (Szapocznik, Scopetta & King, 1978). The finding permitted us to articulate a culturally compatible theory of change which incorporated an understanding of both the transcultural therapeutic change processes and the culture specific content required to intervene with this population.

A second area of inquiry that directed us in refining our theory of change and defining our intervention modality was our work investigating the strains of acculturation. These studies showed that different rate of acculturation among family members may cause disruptions within the family that require direct intervention (Szapocznik & Kurtines, 1979; Szapocznik, Scopetta, Kurtines, & Aranalde, 1978; Szapocznik, Kurtines & Fernandez, 1980). More specifically, we demonstrated that normal transcultural family processes may combine with acculturation processes to exaggerate intergenerational differences and exacerbate intrafamilial conflicts (Szapocznik, Santisteban, Kurtines, Perez-Vidal & Hervis, 1984). A prototypical example can be found in the case of Hispanic immigrants who find themselves in a bicultural context. In this case, the adolescent's normal striving for independence combines with the adolescent's powerful acculturation to the American cultural value of individualism. The parent's normal tendency to preserve family integrity, on the other hand, combines with a tenacious adherence to the Hispanic cultural value on strong family cohesion and parental control. The combination of the intergenerational and cultural differences exacerbate intrafamilial conflict in which parents and adolescents feel alienated from each other. Results of these studies also suggested that structural family therapy was well suited for the treatment of these intergenerational/acculturational problems (Szapocznik, Scopetta, & King, 1978).

Structural family therapy is particularly well suited to address the kinds of problems observed in our population because it is possible to separate content from process. At the content level, the cultural and intergenerational conflicts can be the focus of attention and make the therapy particularly attuned to the Hispanic family. At the process level, structural family therapy seeks to modify the breakdown in communication resulting from these intensified cultural and intergenerational conflicts. More specifically, in treating Hispanic families, the content of therapy may be issues of cultural differences, differences in rates of acculturation, and parents adjustments to changes in their adolescent. Work at the process level promotes more adaptive communication between family members thus dissolving barriers to discussion of topics such as those mentioned above. In this fashion, therapy can be tailored to the specific and unique cultural and intergenerational conflicts.

These theoretical advancements led directly to our initial efforts to investigate the therapeutic efficacy of a family oriented intervention with Hispanic families. A series of pilot research studies (Scopetta, Szapocznik, King, Ladner, Alegre & Tillman, 1977) compared individual, conjoint family and family ecological interventions. These pilot studies provided evidence that structural family therapy was compatible with the issues and problems of our Hispanic population. However, they also suggested the need to modify certain intervention components, such as making the modality strategic and time-limited. To distinguish the particular structural family therapy approach that emerged from this phase of our work we termed it Brief Strategic Family Therapy (BSFT). Since 1975 we have conducted a large number of funded studies on BSFT and on its specialized applications (see Szapocznik, Kurtines, Santisteban, & Rio, 1990)

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Bicultural Effectiveness Training and Family Effectiveness Training

Our first efforts at developing specialized applications of BSFT sought to address the impact that immigration and acculturation had on our families. Some families required an intervention designed specifically for this constellation of problems. As a result, we developed Bicultural Effectiveness Training (BET) (Szapocznik, et al 1984), an intervention to enhance bicultural skills in two-generation Hispanic immigrant families by addressing the family conflicts that arose from differential intergenerational acculturation rates, and the consequent adolescent disruptive/conduct problems. BET, a 12 session psychoeducational intervention, is based on a strategy that provides families and family members with skills for effectively coping with manifestly conflicting cultural values and behavioral expectations. BET teaches families to feel enriched rather than stressed by the unique opportunities provided them in their daily transcultural existence.

A clinical trial was conducted to investigate the relative efficacy of BET in comparison to structural family therapy (Szapocznik et al, 1986). Forty-one Cuban American families with a behavior problem adolescent were randomly assigned to either BET or a structural family therapy condition. The results of this study indicated that BET was as effective as structural family therapy in bringing about improvement in adolescent and family functioning. These findings suggested that BET could accomplish the goals of family therapy while focusing on the cultural content that made therapy attractive to Hispanic families.

Subsequently, we combined BSFT and BET into a prevention/intervention modality we called Family Effectiveness Training (FET) (Szapocznik, Santisteban, Rio, Perez-Vidal, & Kurtines, 1986). The efficacy of FET was evaluated in a study with 79 Hispanic families of

children ages 6-11 presenting with emotional and behavioral problems (Szapocznik, Santisteban, Rio, Perez-Vidal, Santisteban, and Kurtines, 1989). Families were randomly assigned to FET or a Minimum Contact Control condition. The results indicated that families in the FET condition showed significantly greater improvement than did control families on dependent measures of structural family functioning, adolescent problem behaviors as reported by parents, and child self-concept. Thus, the intervention was able to successfully improve functioning of both the child and the family. Furthermore, follow-up assessments indicated that the impact of the FET intervention was maintained.

Measurement Issues

Our efforts to evaluate culturally competent interventions forced us to make advancements in the area of culturally appropriate measures and methods. Our main research challenge was to develop a measure for Hispanic families that was appropriate for our structural theory, clinically relevant, and psychometrically sound.

To launch this work, we borrowed from the work of Minuchin and his colleagues with the Wiltwick Family Tasks (Minuchin, et al., 1978), a structured procedure in which families are instructed to plan a menu, discuss their likes and dislikes about other family members, and discuss the last family argument. The tasks were useful as standard stimuli, but the scoring of these tasks presented problems of standardization and reliability. For this reason, we reorganized the scoring procedure into broad, theoretically and clinically important dimensions of structural family functioning; standardized the administration procedure (Hervis, Szapocznik, Mitrani, Rio, & Kurtines, 1991); developed a detailed manual with anchors and examples to enhance reliability and replicability of the scoring procedure; and obtained validational evidence for the usefulness

and non-obtrusiveness of the procedure in family therapy outcome studies (Szapocznik, Rio, Hervis, Mitrani, Kurtines, & Faraci, 1991).

The Structural Family Systems Ratings (SFSR) developed in response to this research need, defines family structure as the family's repetitive patterns of interactions along five interrelated dimensions. Structure is the basic and most important dimension and is a measure of leadership, subsystem organization, and communication flow. Resonance is a measure of the sensitivity of family members toward one another. It focuses on boundaries and emotional distance between family members. Developmental Stage assesses the extent to which each family member's roles and tasks correspond with the developmental stage within the family Identified Patienthood assesses the extent to which the family operates as if the primary family problem is the fault of one member who exhibits the symptom Last, Conflict Resolution is a measure of the family's style in managing disagreements and conflicts.

The psychometric properties of the SFSR were investigated using data from over 500 Hispanic families participating in treatment. Content and construct validity were both explored (Szapocznik, et.al., 1991). Content validity was built into the SFSR by developing the scales to tap structural concepts. Construct validity was extensively examined revealing that the SFSR measures improvements resulting from structural family therapy and that it discriminates between interventions that are and are not expected to bring about structural family change. Data addressing the factor structure of the scales and interrater reliabilities were also obtained.

The SFSR represents one of the most important measurement advances of our program of research. The SFSR is a theoretically meaningful measure of structural family functioning that has become an essential tool for answering some of the critical questions posed by subsequent

steps in our program of research. We have continued to refine the SFSR, including extending its use to non-research clinical settings (cf. Szapocznik & Kurtines, 1989) and adapting it for the range of family constellations that occur in our minority communities of the 1990s, including single parent and extended kinships.

Engaging families into treatment

At that stage in our cumulative research program an additional clinical/application challenge confronted us: engaging families into the intervention. In response, we developed a culturally competent intervention based on our structural and systems perspectives. The approach, Strategic Structural Systems Engagement (SSSE) (Szapocznik, Perez-Vidal, et al., 1990; Szapocznik & Kurtines, 1989) is based on the premise that whatever the initial presenting symptom may be, the initial obstacle to change is "resistance" to coming into treatment. When "resistance" is defined as the symptom to be targeted by the intervention, the structural systems model also defines it as a manifestation or symptom of the family's current pattern of interaction. Therefore, we have argued (Szapocznik, Perez-Vidal, et al., 1990) that the same systemic and structural principles that apply to the understanding of family functioning and treatment also apply to the understanding and treatment of the family's resistance to engagement.

It follows from the strategic structural model that the solution to overcoming the undesirable "symptom" of resistance is to restructure the family's patterns of interaction that permit the symptom to exist. Once the first phase of the therapeutic process in which resistance is overcome and the family agrees to participate, has been accomplished, it becomes possible to shift the focus of the intervention toward removing the presenting symptoms of problem behavior and drug abuse. A more recent reconceptualization of this work (Santisteban &

Szapocznik, 1994) has refocused the locus of resistance to the therapist because it became clearer that when therapists changed their behavior (by using SSSE techniques) the family's "resistance" was overcome.

In a process similar to how theoretical advances in our structural family therapy intervention theory demanded progress in our measurement strategy, theoretical advances in understanding the nature of resistance to entering treatment, and the concomitant advances in developing strategies for overcoming this type of resistance, required a reconceptualization of our approach to treatment outcome measures. Because the problem to be addressed was that of getting the family into therapy, we had to move beyond the analysis of pre- to post-outcome measures to rates of engagement and maintenance through treatment completion as indices of intervention efficacy.

In most treatment outcome studies, outcome is assessed for those subjects who complete the intervention or control conditions. Since so many studies suggest that there are no differential treatment effects among completers, differential retention/attrition rates may be a critically important measure that distinguishes between different types of interventions (Kazdin, 1986). Acknowledging that treatment outcome only assesses efficacy on a highly selected sample (treatment completers) highlights the enormous importance that attrition and retention have as complementary measures of efficacy. It follows that interventions should be assessed first in terms of their ability to engage and retain subjects/clients, and second using the more conventional measures of outcome efficacy applied to treatment survivors.

The efficacy of SSSE in engaging and bringing to therapy completion Hispanic families with drug abusing youths, was tested in a major clinical trial (Szapocznik, Perez-Vidal,

Brickman, Foote, Santisteban, Hervis & Kurtines, 1988) in which 108 Hispanic families of behavior problem adolescents (who were also suspected of, or were observed using drugs) were randomly assigned to one of two conditions: SSSE, or an Engagement as Usual control condition. In this control condition, the clients were approached in a way that resembled as closely as possible the kind of engagement that usually takes place in outpatient centers. In the experimental condition client-families were engaged using techniques developed specifically for use with families that resist therapy. Considerable work was done in developing a manual for the experimental condition (Szapocznik & Kurtines, 1989; Szapocznik, Kurtines, et al., 1990) and in describing modality guidelines for both conditions in order to ensure the standardization and replicability of the study.

There were two basic findings from the study. First, SSSE demonstrated substantial efficacy in engaging and maintaining families in treatment. While 57% of the families in the Engagement as Usual condition failed to engage into treatment, the rate was only 7% in the SSSE condition. Of those who engaged into treatment, 41% in the Engagement as Usual condition dropped out compared to 17% in the SSSE condition. Thus, of all of the cases that were initially assigned, 77% in the Structural Systems Engagement condition were successfully terminated compared to only 25% in the Engagement as Usual condition. Second, adolescents in both conditions showed significant decreases in problem behavior and these changes were not significantly different across conditions. Therefore, the efficacy of the SSSE intervention was in extending the benefits of therapy to many more families by increasing the rate of engagement and retention in treatment

A second study designed to replicate and extend these engagement findings was recently

completed (Santisteban, Szapocznik, Perez-Vidal, Kurtines, Murray, & LaPerriere, 1996). This study was designed to provide for a more rigorously controlled experimental test of the engagement interventions by using a larger and more multicultural sample, a more stringent criterion for successful engagement, and two control conditions instead of one.

Large, statistically significant differences were found between the experimental engagement condition and the two control conditions for rates of engagement. In the experimental condition, 81% of the families were successfully engaged, compared to 60% of the control families. Although the overall rates of the second engagement study appear lower than those of the first study, this is due to the more stringent criteria for engagement used in the second study. When the rates of engagement in the second study were compared with those of the original study using the original criteria, the results indicated that there were no significant differences between the two experimental engagement conditions; 93% in the first study and 88% in the second.

We also studied whether culture/ethnicity might influence intervention efficacy within our multicultural Hispanic sample. The data indicated dramatically different rates of engagement across Hispanic groups. Among the non-Cuban Hispanics (composed primarily of Nicaraguan families but including also Columbian, Puerto Rican, Peruvian, and Mexican families) assigned to the experimental condition, the rate of engagement intervention failure was extremely low, 3%. In contrast, among the Cuban Hispanic sample assigned to the experimental condition, the rate of intervention failure was relatively high, 36%. A more fine-grained case by case analysis of these findings suggested that the very different histories and trajectories of these Hispanic subgroups within the same Dade County community may have resulted in different patterns of

resistance to engaging into therapy. These findings allowed us to articulate in an exploratory way the mechanism by which culture/ethnicity and other subtle contextual factors may influence clinical processes (Santisteban et al., 1996, Szapocznik and Kurtines, 1993) related to engagement.

Comparing structural family therapy with other modalities

Our research up to this point had concentrated on the development, refinement, and testing of structural family theory and strategies with Hispanic families with antisocial problem behavior youth. However, the question of the relative efficacy of a structural family systems approach, when compared to other widely used clinical interventions, became our next challenge. This research question was addressed primarily in two outcome research studies..

The first outcome study compared BSFT and individual psychodynamic child therapy, with a recreational activity group as a control. An experimental design was achieved by randomly assigning 69 six to twelve year old Hispanic boys to the three intervention conditions (Szapocznik, Rio, et al., 1989). With respect to treatment efficacy, the control condition was significantly less effective in retaining cases than the two treatment conditions, with over two thirds of dropouts occurring in the control condition. These attrition results support our earlier recognition that drop out rates are important outcome measures that may distinguish the efficacy of different intervention/control conditions. A second finding was that the two treatment conditions, structural family therapy and psychodynamic child therapy, were equivalent in reducing behavior and emotional problems based on parent- and self-reports. A third finding involves the greater efficacy of family therapy over child therapy in protecting family integrity in the long term. In this study, psychodynamic therapy was found to be efficacious in bringing

about symptom reduction and improved child psychodynamic functioning; but it was also found to result in undesirable deterioration of family functioning. The findings provided support for the structural family therapy assumption that treating the whole family is important, because it improves the symptoms and protects the family, whereas treating only the child may result in deteriorated family functioning. A fourth important finding revealed that there is a complex relationship between specific mechanisms (family interaction vs. child psychodynamic functioning) and related outcome variables. Examination of the relationship between the putative etiologic factors postulated by the two theoretical/clinical approaches, on the one hand support some of the underlying assumptions of psychodynamic theory. On the other, it does not support some of the underlying assumptions of family therapy, viz., that changes in family functioning are necessary for symptom reduction. Hence, there was considerable value to extending the investigation beyond a simple horse race to a study of postulated underlying mechanisms.

Our second major outcome study further extended our work by testing the efficacy of structural family therapy in reducing behavior problems and investigating whether changes in family functioning mediated reductions in antisocial problem behavior. In this study 79 Hispanic families with an adolescent referred for conduct problems were randomly assigned to one of two treatment conditions; BSFT, or a group therapy control condition.

Outcome data were analyzed using two complementary approaches. The first was by Repeated Measures Multivariate Analysis of Variance (MANOVA) and the second by analysis of reliable/clinically significant change as recommended by Jacobson and Traux (1991). The latter method complements the more commonly used analyses of group means by providing a

case by case index of change. The MANOVA and follow-up univariate analyses revealed that our experimental group changed significantly and our control group did not on our two dependent variable indicators of antisocial problem behavior; parent report of Conduct Disorder and Socialized Aggression from the Revised Behavior Problem Checklist (Quay & Petersen, 1987). The results of the analyses of reliable/clinically significant change corroborated the multivariate approach, indicating that a substantially larger proportion of family therapy cases showed clinically significant improvement on the same outcome dimensions of Conduct Disorder and Socialized Aggression.

Basic Issues in the Evolution of a Culturally Competent Intervention

At the foundation of a maturing program of research is an understanding of the issues in conducting culturally competent work and a theoretical framework that helps guide the research efforts. It has been our experience that in the evolution of a culturally competent program of intervention research with Hispanics, several basic research issues have to be addressed that pertain to the clinical development of culturally competent interventions and to the evaluation of the interventions. With respect to developing interventions, primary issues entail articulating a theoretical model of both the transcultural processes and culture specific content to be included in the intervention as well as formulating a framework for implementing the intervention in a culturally compatible manner (i.e., that incorporates the relevant transcultural processes and culture specific content). Primary issues with respect to evaluating interventions include identifying, adapting, and/or developing culturally appropriate measures and methods for evaluating the interventions and actually conducting outcome studies that evaluate the efficacy of the intervention.

Basic to all culturally competent interventions is a theoretical model articulating the factors and processes that contribute to the development or maintenance of the problem behavior. This model is not necessarily culturally specific, but attends to the general psychosocial mechanism and processes that are theoretically or empirically linked to the pattern of behavior targeted for change. In the case of our theoretical framework, which focuses on repetitive patterns of interactions, these processes are transcultural, with similar process likely to be operating across ethnic/cultural groups. However, researchers must also be aware of how culture specific processes may shape the developmental course of the problem behavior.

In our own work, and in that of Rogler and colleagues, the process of acculturation and its accompanying stress and conflict reflect a specific social/clinical process, experienced by the population we were working with, that also had to be integrated into the theoretical foundations of the intervention. For us, the process of differential acculturation was critical and evident in the strained and altered patterns of interaction in our clinical families.

Another excellent example of establishing a theoretical foundation for building a systematic program of culturally competent research with Hispanic antisocial and behavior problem youth, is a theoretical model and research plan for preventing substance use in Hispanic adolescents outlined by Schinke and colleagues at Columbia University School of Social Work (Schinke, Moncher, Palleja, Zayas. & Schilling, 1988; Schinke, Schilling, Palleja, & Zayas, 1987). Using basic theories of stress, coping and social support, the group frames a basic theoretical model linking substance use in adolescence to purportedly causal antecedent conditions. The model and research plan also suggests about how Hispanic values, customs and traditions could be integrated into the model to help guide culturally competent interventions.

Simultaneously, it acknowledges the difficulties in transferring technologies across ethnic groups.

Once a general model of theoretical mechanisms is articulated, it must then be translated into a clinical intervention. At this stage the challenge is to formulate a framework for integrating the relevant transcultural therapeutic processes and the cultural specific content. In our work, we adopted the modality of structural family therapy which contained core concepts, methods, and procedures compatible with our population's cultural views. This intervention also effectively targeted the mechanisms of family dysfunction that were articulated in our general theory of problem behavior development. Rogler and colleagues have argued for a slightly different approach, one which starts with the client's cultural values as a beginning for the design of the intervention and uses these as the "vehicle" for therapeutic change (Costantino & Rivera, 1994; Rogler et al, 1987). However, many of the therapeutic techniques in their interventions, modeling, sharing personal experiences and feelings, role playing and reinforcement of imitative behaviors, and the probable mechanisms of change, cognitive restructuring and shaping behavior through modeling, are not intervention techniques or change mechanisms specific to Puerto Rican youth. Rather, they are transcultural processes that have been rendered more accessible to change through use of culturally compatible content.

With respect to evaluating interventions, developing measures that are, as Kazdin (1986) recommended, theoretically appropriate, clinically relevant, and with psychometric properties adequate for use in research settings, is a critical step. This process involves ensuring that the measures and methods are psychometrically as well as linguistically comparable, i.e., the extent to which the psychological and sociocultural concepts and constructs are comparable across

populations.

Our efforts to investigate the effects of acculturation on the Cuban immigrant population of Miami required a great deal of work designing and creating an adequate measure of acculturation that would reflect our view of biculturalism and be sensitive to the changes we expected in our interventions. From this need emerged the Behavioral Acculturation Scale (Szapocznik, Scopetta, Kurtines, et.al., 1978) and the Bicultural Involvement Questionnaire (Szapocznik et al, 1980). The use of both of these instruments in our clinical outcome studies helped to shed light on some of the complex processes by which culture affects individuals and families.

Our work with adapting the Revised Behavior Problem Checklist (Quay & Petersen, 1987) for use with Hispanic populations was slightly more complex. The first step in adapting this measure was to translate it into Spanish using the techniques of translation and back translation (Kurtines & Szapocznik, 1995). The second step involved collecting data using the Spanish language version and to evaluate the cross-cultural consistency of the RBPC's factor structure with our population (Rio, Quay, Santisteban, & Szapocznik, 1989). The results of our factor analysis yielded a six-factor structure with high degree of comparability with the original version. This work comprised an important step in our program of research, providing a cross-culturally validated measure for assessing antisocial problem behavior in Hispanic youth.

The final step in the evolution of a culturally competent intervention is conducting outcome studies that evaluate the efficacy of the intervention and interpretation. Evaluation of the program is also conducted in a culturally sensitive manner, but is dictated as much by basic research design and statistical analysis techniques. Ideally, this step of evaluation can highlight

both the efficacy of the transcultural therapeutic change processes and the efficacy of any culture specific processes or content. Results of this phase of the evolution of culturally competent interventions must yield information that can feed back to theory and clinical development. If the results suggest an ineffective program, researchers must be willing to consider possibilities of implementation failure and/or theory failure (Weiss, 1972). Implementation failure might occur for many reasons including lack of intensity or fidelity/integrity to the intervention, or lack of cultural compatibility with the views of the population. Theory failure might result from a misspecified theoretical model of transcultural or culture specific developmental mechanisms.

Within a program of culturally competent research each phase of the research endeavor must be couched within a basic understanding of cultural issues. Description of those issues can be found in the very large literature based mostly on observations that identify cultural characteristics of Hispanics that are recommended for careful consideration.

Bernal, Bonilla, and Bellido (1995) capture some of the most important recommendations in their articulation of a framework for research that can be used as a guide for developing culturally sensitive interventions or adapting existing psychosocial treatments for Hispanic clients. Their framework consists of eight partially overlapping dimensions to which researchers developing a culturally competent intervention should attend. The first, and perhaps most basic is the dimension of *language*. Because language is the "carrier of the culture", culturally syntonic language is critical to ensuring that clients are receiving the intervention as the therapist has intended. The second dimension of *persons*, refers to the client therapist match. Research has indicated that ethnic and racial similarities between therapist and client can improve therapeutic outcome (see Sue,et al., 1994). The dimension of *metaphors* refers to the culturally consonant

use of symbols and concepts in the intervention. The authors define the fourth dimension , *content*, as one of cultural knowledge. This dimension reflects the appreciation of cultural information about values, customs and traditions. In developing a culturally competent intervention for Hispanics, researchers might begin with familiarizing themselves with basic Hispanic values, while also considering the uniqueness of the particular ethnic group participating in their intervention. The degree to which treatment concepts are consonant with the cultural context defines the fifth dimension: *concepts*. The manner in which problems are conceptualized and the treatment model is communicated must be consistent with the belief system of the clients. The *goals* of treatment represent the sixth dimension in their framework. Again, the goals of treatment must be presented in a manner consonant with the cultural values held by the client population. Establishing treatment goals or communicating goals in a manner that is discrepant with those held by the client reduces the likelihood of an effective outcome.

The methods by which the intervention is delivered is a critical issue for consideration. While many different intervention modalities exist as options for developing an intervention for antisocial behavior problem youth, cultural knowledge may dictate the selection of one over all others. One example of this is the general recommendation for family therapy as the treatment modality of choice for Hispanic clients because this intervention modality is congruent with the dominant Hispanic worldview of "familism" (Sabogal, Marin, Otero-Sabogal, Marin, Perez-Stable, & Eliseo, 1987). The eighth and final dimension to their framework is *context*. Context refers to the changing social, political, economic processes that create unique situations in each intervention.

This framework proposed by Bernal,et al .(1995), represents a compilation of the issues

which underlie culturally sensitive programs. But, as noted earlier, cultural competence encompasses more that cultural sensitivity. It also includes the mastery of knowledge and skills that comes most efficiently from progressive experience of conducting a program of study that integrates theory, research and application. Issues discussed in the framework must be applied with regard to each of the basic research issues in the evolution of a culturally competent intervention.

Future Directions

In closing, the need to develop psychosocial interventions that can be used in contexts of cultural diversity takes on a larger significance in view of the broader social, political and historical trends that are taking place. This is especially the case as we, in America, become an increasingly culturally diverse society. Projections indicate a dramatic shift in racial and ethnic composition of the U.S. population over the next few decades, with Hispanics surpassing African americans as the largest "minority" (Yung & Hammond, this volume). It is important that basic research on culture and the development of culturally competent interventions must continue to evolve, and researchers must be cognizant of the dynamic nature of culture.

In addition to attending to the dynamic nature of culture, it is important that culturally competent interventions address the multitude of changing historical and social conditions and the multiple systems that have an impact on the target populations. Hence, in its latest evolution, our work has become more multisystemic as well as structural. This structural multisystemic, family-focused approach based on Structural Ecosystems Theory (Szapocznik et al, 1996) now pervades our efforts to develop and evaluate culturally competent interventions at many levels, ranging from clinical interventions to neighborhood based and school based interventions.

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